

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035995

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8776 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 17 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3630 Connecticut			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carrie C. Butts			4. DATE OF DEATH Month Day Year 9-9-62			5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>			
8. DATE OF BIRTH 9-26-1877		9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					
10b. KIND OF BUSINESS OR INDUSTRY at Home				11. BIRTHPLACE (City and state or country) Ill. Oak Grove, U.S.A.				12. CITIZEN OF WHAT COUNTRY					
13a. FATHER'S NAME James J. Wilson				13b. MOTHER'S MAIDEN NAME Julia Ann Holt				14. NAME OF HUSBAND OR WIFE Late William E. Butts					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Hazel Wigger-3630 Connecticut Str.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH 1 year			
DUE TO (b) generalized low arteriosclerosis										10 years			
DUE TO (c) 420.0													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year				20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 8-22-62 to 9-9-62 and last saw her alive on 9-9-62 Death occurred at 9:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Marvin G. Fingerhood, M.D.						22b. ADDRESS 5600 Arsenal Street			22c. DATE SIGNED 9-10-62				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 12, 1962		23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park.			23d. LOCATION (City, town, or county) St. Louis County, Mo.			(State)			
24. FUNERAL DIRECTOR Kriegshauser-4228 S.Kingshighway Blvd.						25. DATE RECD. BY LOCAL REG. SEP 11 1962		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.					

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edwin A. McArthur

Licensed Embalmer No. 3024

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.